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A sociological study of the needs of the elderly in a subarea of Hampton, Virginia

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A SOCIOLOGICAL STUDY OF THE NEEDS OF THE ELDERLY IN A SUBAREA OF HAMPTON, VIRGINIA

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DEDICATION

This thesis is dedicated to our heavenly father, the most elderly of us all.

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ABSTRACT

The purpose of this study is to examine (1) perceived and reported needs, (2) status characteristics associated with these need areas, and (3) the reported desire for social service help among some of the elderly in Hampton, Virginia. A door-to-door survey of all residents 55 and over was conducted in a portion of Phoebus, Hampton by the Phoebus Social Work Helper from February to July 1977.

The findings suggest that physical and dental health are key variables associated with all but one of the perceived or self-reported need areas, which include household duties, income maintenance, visitation, and group participation. This finding is predicted by most gerontological theories such as the developmental theory and the social integration framework. Monthly income was found to be the most highly associated status characteristic with the remaining need area, that of transportation. It is important to note that the variance accounted for in the dependent variables was modest. The relationships found were in the directions anticipated, but any interpretations must be labeled tentative.

With regard to the desire for social service assistance, the findings demonstrate that less than 10 percent of the respondents desire help with any one of the need areas except physical and dental health. This suggests that there is little apparent relationship between empirically identified needs and the desire to receive social service assistance. An interpretation of this finding is provided by the continuity theory and social integration framework. The continuity theory suggests that respondents obtained most of their shared social values in early adulthood and carried them into old age. This includes values related to receiving social service assistance. The findings reported here suggest that social service assistance is defined as charity and is, therefore, to be rejected. The policy implications of these findings are discussed in the conclusion of the tnesis.

A SOCIOLOGICAL STUDY OF THE NEEDS OF THE ELDERLY IN A SUBAREA OF HAMPTON, VIRGINIA

INTRODUCTION

This study examines (1) perceived and reported needs, (2) status characteristics associated with these need areas, and (3) the reported desire for social service help, among some of the elderly in Hampton, Virginia. The primary data analyzed were originally collected by the Phoebus Social Work Office for the purposes of obtaining an indication of the needs of the elderly in the study area and their desire for social service help. The purposes of this thesis are similar; but, in addition, will examine relationships between respondents' status characteristics and their perceived and reported needs.

The importance of addressing the needs of the elderly has been recognized by Congress through the Older Americans Act of 1965. This act provided for the establishment of an Administration of Aging within the Department of Health, Education, and Welfare. The act declared as objectives for older Americans: "(1) an adequate income, (2) the best possible physical and mental health, (3) suitable housing, (4) full restorative (rehabilitative) services, (5) opportunity for employment without age discrimination, and (6) retirement in health, honor, and dignity"(Loether, 1967:9). When examining the general welfare of the elderly, Woodruff and Birren report that in 1973, 16.3 percent of the Americans 65 and over fell below the low-income level, while 11.1 percent of the total U.S. population fell below this level (1975:341). This low-income level is based on the comparison of the income of a particular family to a subsistence income.

Past generations relied on family and voluntary community efforts to meet the needs of the elderly. However, during the Great Depression of the 1930s, the inadequacy of individual and voluntary efforts was recognized. Since that time, the federal government has instituted various separate programs such as Social Security, Supplemental Security Income, Food Stamps, and Medicare and Medicaid with the objective of alleviating the needs of the elderly.

On a local level, many social service programs have begun to devote special attention to the needs of the elderly (Field, 1972:161). These programs address not only the requirements for maintaining an adequate income and health, but also needs related to performing household duties, obtaining transportation, and remaining socially involved. A further concern of local social service programs, such as those in the Hampton, Virginia, area, has been to determine those services which elderly persons desire. In this regard Matilda White Riley, a prominent gerontologist, has stated that "In the absence of more compelling alternatives, a number of practitioners would hope to establish priorities in the light of older people's own preferences and desires and the relative importance to them of their varying needs"(Riley, 1979:13). Little published research, however, has dealt with the desire for social service help among the elderly. These needs of the elderly and their desire for social service assistance, which should be addressed at both national and local levels, are the subjects of this thesis.

The study is based on 116 personal interviews conducted by the Phoebus Social Work Helper in the spring of 1977 to determine (1) the perceived and reported needs of some of the elderly population in Hampton, Virginia, and (2) their desire for social service help. A

detailed description of the methodology is provided in Chapter II of this thesis. The questionnaire used was developed by the Phoebus Senior Social Worker, and is provided in Appendix A. A door-to-door survey was conducted of all residences in an approximately 1.5 square-mile area of Phoebus. One hundred and sixteen (116) interviews were completed from 635 addresses contacted. No response was obtained from approximately one-fifth of the residences. Businesses and houses obviously deserted were skipped.

Chapter I provides a discussion of prevailing gerontological theories with an emphasis on the social integration conceptual framework. Chapter II provides a description of the study area, sample and data collection procedures, and the methods of analysis employed. Chapter III summarizes the results of the analysis and a discussion of the theoretical implications of the findings. Finally, Chapter IV discusses policy implications of the findings, limitations of the study, and suggestion for further research.

CHAPTER I

THEORIES IN GERONTOLOGY WITH AN EMPHASIS ON THE SOCIAL INTEGRATION FRAMEWORK

The Study of Aging: An Overview

Growing old is a dynamic process which includes bodily changes, redefinitions of social identities, and adjustments in psychological functioning. It has only been since the beginning of the twentieth century that multidisciplinary interest in aging has emerged. In the early 1900s the work of Elie Metchnikoff helped to awaken interest in the study of the elderly, which led to the establishment of the International Club for Research on Aging (Hendricks and Hendricks, 1977:19). By the 1930s, the interest in older Americans had gained the attention of lay people and scientists alike, which helped pave the way for Social Security, periodic course offerings in major universities, and publication of a number of landmark treatises, e.g., E. V. Cowdry's edited volume Problems of Aging (1939), and the convening of gerontological conferences. By the end of the 1940s the Gerontological Society was founded and with it the publication of the Journal of Gerontology, which emphasizes sociological, biological, and psychological aspects of aging.

In recent years, research in Gerontology has produced an enormous flood of books and over 5,000 articles yearly (Kent, 1972). An attempt at the Andrus Gerontology Center to compile a listing of the biomedical and social science research and the applied professional aspects of

aging for the years 1954-1974 has resulted in approximately 50,000 entries. The study of aging has become quite diffuse, with researchers specializing in particular aspects of aging within their respective disciplines. Psychologists emphasize cognition, learning and memory, and psychophysiology. Biologists focus on areas such as cellular mechanisms and physiology. Sociologists specialize in areas such as the socialization for old age, status role changes and social needs of the elderly (Woodruff and Birren, 1975:3). With respect to programs for the elderly, estimates initiated by the 1967 amendments to Older Americans Act indicate that there were, at the beginning of the 1970s, roughly 330,000 people working with the elderly for the provision of basic services. Projected needs for trained geriatric personnel, determined by the 1975 Special Committee on Aging in the Senate, concluded that hundreds of thousands of workers must still be trained in the next five years or so to satisfy the growing requirements of the field of aging.

The present study is concerned with the sociological aspects of aging and, in particular, with the needs of the elderly. Within sociology, many theories have been used to explain the aging process; and as might be expected, some provide more insight into the needs of the elderly than others. One of the first theories was the disengagement theory which contends that society and elderly individuals mutually disengage from each other as a consequence of inherent factors which are functional to the aging individual and to society. Specifically, these inherent factors refer to an instinct or natural drive of the elderly and society to mutually disengage. Critics of this theory such as Peppers (1976) and Maddox (1970) contend that the elderly desire

social activity rather than disengagement. When applying the disengagement theory to the needs of the elderly, the theory predicts that the older the individual, the less need or desire for social involvement. It should be noted that the theory does not recognize differing needs among the elderly resulting from differing social conditions such as income or education.

One reaction to the above framework was the introduction of activity theory by Tobin and Neugarten (1961). This perspective holds that elderly individuals desire activity and are less satisfied with their lives when their activities are reduced. The theory has been criticized for not accounting for an individual's preparation for death, as well as overlooking individual income and educational differences (Thompson, 1973; Smith and Lipman, 1972). When applied to the needs of the elderly, the activity theory, like the disengagement theory, focuses primarily on social involvement and does not acknowledge differing needs of the elderly resulting from differing social conditions.

Role theory, developmental theory, and subculture theory are three additional sociological approaches which have been applied to the study of the aging process. Role theory attempts to explain the aging process by examining roles lost, retained, and added (Riley and Foner, 1968). Roles lost are the result of factors such as failing health, forced retirement, children leaving home, and ambitious younger people replacing older persons from positions of authority in community organizations. Lost roles might include group memberships, employment, and/or that of spouse. Roles retained might relate to membership in community organizations, friendship patterns, and marriage. Roles added might include that of grandparent, fosterparent, and/or widowhood

and retiree. When applied to the needs of the elderly, role theory predicts that as roles are lost, certain needs will develop. Thus, individuals who lose roles as a result of poor health, for example, may develop a need for help with such roles as household duties, transportation, income maintenance, and/or social involvement.

The developmental theory is an interdisciplinary approach encompassing biology, psychology, and sociology. Generally, when applied to the aging process, this theory contends that people change their everyday behavior according to developmental stages over time as well as their stated goals and relationships to others (Bengston, 1973). From a biological standpoint, there is a predicted decrease of physical strength and an increase in the probability of disease. From the psychological perspective, there is a predicted change in orientation of life goals. Finally, from the sociological perspective, there is a predicted change in responsibility, power, and prestige within society (Carp, 1968). When applying this theory to the needs of the elderly, developmental theory predicts that with increased age there will develop biological, psychological, and sociological needs. For example, the elderly person may develop needs for more intensive physical and dental care, help with household duties, income maintenance, transportation, and social involvement.

The subculture theory has been applied to the aging process by Arnold M. Rose (1965). Applied to aging, this theory contends that the elderly are developing a subculture, that is, a group of individuals with shared norms, values, and beliefs, and are interacting with their own kind significantly more than with others. The elderly have been characterized as a subculture due to their increasing numbers in the

population; presumed self-segregation into retirement communities, inner cities, and regionalism (e.g., Florida, California, Texas, Arizona); common historical experiences; similar health and economic conditions; and shared stereotypes. When applied to the needs of the elderly, this theory recognizes that the elderly do have needs which are unique to their age cohort. For example, the President's Council on Aging (1963) concluded that the elderly cohorts have a strong desire to avoid social services which are defined by their values and beliefs as charity, rather than a right. Younger age cohorts, however, when reaching old age and becoming eligible for these same social services, may define these services as a right rather than as charity and, consequently, feel no desire or need to avoid them. A major criticism of the subculture theory is that it does not recognize status differences and the varying norms associated with them. Further, Binstock (1976) points out other significant heterogeneous characteristics of the elderly, such as geographical location and attitudes.

The last sociological theory to be discussed here is continuity theory which contends that individuals obtain their values, need patterns, and beliefs at a relatively young age and then retain these values throughout their lives (Maddox and Douglass, 1974). When considering the needs of the elderly, continuity theory predicts that the values held by the elderly toward their current personal and social needs, and the use of social services to satisfy these needs, are the same values that the elderly held in middle age or earlier. For example, the experience among elderly of the Great Depression, which occurred in their youth, may have influenced them at that time to place a high value on economic security which they have carried into their

later years of life. The theory is useful in the sense that it acknowledges the importance of values in determining how the elderly view their personal and social needs, as well as the social services designed to satisfy these needs.

Although not all inclusive, the above do represent the more prominent sociological theories of aging. A recently introduced and more comprehensive conceptual framework incorporates several of these theories (Rosow, 1967). The social integration framework combines the importance of: (1) social involvement (social activity and disengagement), (2) social roles, lost, retained, and added, and (3) values. In effect, the synthesis is accomplished by examining the various ways that elderly individuals are integrated in the broader society. The social integration framework, because of its synthesis of several useful aging theories, has been selected for this study as the most fruitful approach for understanding both the perceived needs of the elderly and their use of social services. The remainder of this chapter will describe the social integration framework in greater detail.

Social Integration: A Conceptual Framework

In his volume Social Integration of the Aged, Rosow distinguishes between two different referents of social integration. The first is that of the total social system. With respect to this referent, social integration "concerns the articulation of various institutions and subsystems with one another--the network of linkages, reciprocal relations and functional connections between structures" (Rosow, 1967:8). The second and primary referent for Rosow is that of the individual member--his subjective states and the various ways he relates to and accommodates the broader society.

The integration of individuals to the broader society results from three sets of distinct, but linked factors: (1) social roles, (2) social involvement, and (3) shared social values. The interrelatedness of these factors is most evident with respect to social roles and social involvement because both encompass group participation. It is argued that, together, these three factors provide the means and substance of social integration. To the extent that one's middle-aged roles, social involvement, and shared values are continued into old age, there will be no change in social integration. But as Rosow points out: "To the extent that their lives do change and they cannot maintain their earlier patterns, then their integration may be undermined. . . . In general, the greater the change, the greater the risk of personal demoralization and alienation from society" (Rosow, 1967:9). In support of this position, Marshal Graney (1975) contends that, as older individuals begin experiencing changes, they take on new activities to replace those lost. However, the new activities are never as satisfying as those they are replacing (p. 705). Rosow attributes this change in old age primarily to the loss of social roles, social involvement, and shared social values. He supports this contention by pointing to previous research (Rosow, 1962; Simmons, 1945) which found seven institutional factors governing one's relative position in society. These include: ownership of property and control over the opportunities of the young, command of strategic knowledge and skills, strong religiosity and sacred traditions, strong kinship and extended family bonds in a communal type of social organization, a low productivity economy, and high mutual dependence and reciprocal aid among members. Rosow argues that these seven factors protect the status of old people

in less developed societies, but they are undermined in the United States and other industrialized societies. Consequently, even though the material needs of the elderly may come to be adequate, their social life will deteriorate. Thus, Merton C. Bernstein states, ". . . probably the greatest challenge to society precipitated by technological and demographic change is how to enable the new millions of the elderly to achieve and maintain a sense of dignity and purpose after the years of regular employment are past" (Riley, 1969). Further, Minna Field states:

> Such symptoms as withdrawal, forgetfulness, and temporary confusion may be due to intolerable situations. One might cite such precipitating factors as bereavement, loneliness, economic insecurity or insecurity in any other area, despair, loss of self-esteem, loss of social status and prestige, loss of hope--all of these, so frequently seen among the elderly, may create feelings of worthlessness, frustration, and loss of a significant role and purpose in life. (Field, 1972:115)

Social Roles

Aging clearly involves the inevitable loss of central social roles, as is evident in marriage and employment. A large percentage of the aged experience disruption of marital status, with women being more affected than men. In 1971, 17.1 percent of the men and 54.2 percent of the women over 65 were widowed (Cutler and Harootyan, 1976:63). Statistics show that for each successive ten-year period after age 65, an additional 20 percent of each sex are widowed (Rosow, 1967:14). The experience of bereavement is described by Judith Treas (1976) as typically:

> . . . a trying time of numbness, with subsequent uncontrolled episodes of longing and sorrow interspersed with depression, weight loss, insomnia, and irritability.
> . . . While symptoms usually abate in a few months, one in five widows report never getting over grief. Indeed, the widowed are more likely to report themselves unhappy than are the married. (Treas, 1976:102-103)

Current advances in science, technology, and automation introduce skills so rapidly that occupational obsolescence comes at steadily younger ages. Technological displacement is affecting not only less skilled manual workers but also persons in higher professional and managerial ranks. Unfortunately, as new ideas and techniques are introduced, the experience of the aged becomes obsolete. When attempting to find new employment, older Americans must not only learn new skills but compete against younger, often more educated individuals. These general trends are reflected in the steady decline of older persons in the labor market. Hendricks and Hendricks (1977) have found that for both white and nonwhite men over 65, the percentage in the work force is declining, with nonwhites facing slightly fewer opportunities to work after retirement age (p. 68). For women over 65, Hendricks and Hendricks (1977) have found that the percentage of white women over 65 in the work force has remained about the same since 1900. The percentage of nonwhite women over 65 in the work force has showed a relatively minor decline (p. 68). Those older persons who do work are likely to be either self-employed or the last hired and the first fired. Studies by Juanita Kreps (1963), Hilda Siff (1964), and Margaret Gordon (1963) indicate that the hiring of older people is strictly a function of labor supply. When labor is abundant, they are not hired. When labor is scarce, they are. Indeed, the overall picture on employment shows increasing retirement for people over 65, which results in the loss of such roles as coworker, union member, manager, and fund chairman. This trend toward earlier retirement, however, may be modified or reversed by the newly legislated retirement age act which allows most elderly individuals to work until age 70, if they so desire.

As long as older people continue to work, they are generally in as good a financial condition as they were twenty years earlier primarily because their homes are paid for and their children are financially independent. However, the majority of those in the labor force retire soon after reaching age 65. In 1970, 52.9 percent of the males, age 65, were retired from the labor force. Of the males, age 70, 89.9 percent were retired (Woodruff and Biren, 1975:346). Of those individuals who are fully retired, approximately three-fourths are financially supported by social security benefits alone (Hendricks and Hendricks, 1977:237). Thus, retirement means a major decline in living resources for most elderly. When equating life satisfaction to the loss of income, Walter Chatfield (1977) states: ". . . the observed lower life satisfaction of those retired seems to result primarily from the lower income associated with retirement and not the loss of worker-producer roles" (p. 599).

In conclusion, there are major role losses in old age, with respect to primary roles, such as marital status and employment. Losses of these roles might result in uncertainty as to appropriate or preferred conduct. Some elderly may react by inactivity and boredom. In relation to social integration, Rosow points out that the character of these losses makes them virtually irreversible. Hence, Rosow states, "Older people's integration into society on the basis of their role functions, inevitably declines and deprives them of the participation inherent in these roles" (Rosow, 1967:19).

Social Involvement

The older person's involvement in the community is a similarly contracting one. With respect to formal organizations, older people

belong to a smaller number and hold fewer offices. In those where they retain membership, they increasingly become less active (Wright and Hyman, 1958). With respect to informal associations with family and friends, the trend appears also to be one of fewer associations, if for no other reasons, because of increasing mortality and immobility of family members and friends.

Family and Kinship Networks. With respect to the nuclear family, when a woman's active mothering days are over, she often will experience some degree of demoralization and purposelessness (Treas, 1976: 99). However, these negative feelings are often coupled with feelings of exhilaration, relief, a sense of freedom. Moreover, there is often continuing mutual aid between the generations after children reach adulthood. This is reflected in both financial as well as emotional aid. Judith Treas (1976) states, "Help may take the form of financial assistance, gifts, services, or advice and counseling. Some help is routinely given (for example, child care, chauffeuring, shopping, housekeeping), while other aid may be extended periodically on ceremonial occasions or during crises" (p. 95). With respect to the extended family, the social field of older individuals shrinks as parents, brothers, sisters, and other family members die or become immobile.

The cumulative loss of family members, especially when occurring over a short period of time, results in emotional loss, though the degree of loss is questionable. James Peterson (1970), after reviewing studies on contemporary kin relations, found considerable support for the thesis that family "relations do not offer substantial intimacy or emotional support to aging persons (p. 516). On the other hand, Shanas et al. (1968) state: "By their general health or, more specifically,

the personal and household functions they perform, in the services they receive from their families, and in the frequency of their contacts with children and other relatives, most old people are fairly securely knitted into the social structure" (p. 425). Further, Hendricks and Hendricks (1977) state, "There is no doubt about the salience of familial bonds, they continue to play the single most important role in lives of most elderly" (p. 297). Thus, it appears that family relations do offer some intimacy and emotional support, although the extent of these relations is uncertain.

Friendship Networks. It appears that the elderly as a whole have fewer friends than younger cohorts. This is a consequence of the relatively greater number of friends, of the elderly, who die or become immobile (see Hendricks and Hendricks, 1977; Merton and Lazarsfeld, 1954; and Aldridge, 1959). Older people, who are immobile, are often forced to restrict their friendships to their local neighborhood, or simply to those who will pay them a visit, talk with them on the telephone, and/or correspond by mail (Rosow, 1967:29).

Friendships which do exist have been described by Shanas et al. (1968) as being based on "reciprocity, common interests, inculcated loyalties, and affection"(p. 425). Hendricks and Hendricks (1977) attribute to friendships the potential to shield the aged against negative self-evaluations and point out that even a single close friendship can provide this shield. They state:

> By having several or even a single close friend with whom they can share their thoughts, fears, interests, or objective problems, older people are protected from many of the negative definitions imposed by the larger society and from some of the protean liabilities growing out of the attrition of their social roles. (pp. 296-297)

Hendricks and Hendricks (1977) further state:

> . . . it should not be inferred that isolated individuals necessarily fare less well. . . . It is mostly those who have tried and failed to make friends or else have lost their intimate ties who are particularly susceptible to emotional upset. (p. 298).

In summary, there are losses of personal relationships in old age both from family and friends which result from the inevitability of deaths among family members and friends, and the decreasing mobility of the elderly. As a consequence, older people's integration into society on the basis of their social involvement eventually declines and deprives the elderly of the social integration inherent in this involvement.

Shared Values

James Christenson (1977) defines values as "conceptions of the desirable focusing on generalized end-states arranged in a hierarchy of order" (p. 368). Similar definitions are used by Kluckhohn (1951), Nye (1967), and Rokeach (1973). Robin Williams (1960) has synthesized and abstracted basic American value orientations. In developing dominant American values, Williams used as sources the United States Constitution, writings of the founding fathers, investigation of the Puritan ethic, and popular literature such as the Horatio Algers stories. Dominant American values abstracted include: work, achievement, practicality, the "good life," progress, democracy, individualism and patriotism. Williams attributed to these values the distinction of performing an essentially social integrative function. Similarly, both Parsons (1950:8) and Merton (1957:141) assume the existence of a single more or less integrated system of values in society. Further, Blau (1967:24) comments that:

> Sharing basic values creates integrative bonds and social solidarity among millions of people in a society, most of

> whom have never met, and serves as a functional equivalent for the feelings of personal attraction and unite pairs of associates and small groups.

The crucial point here is whether dominant values are commonly supported by all members of the society. Christenson and Yang (1976), after studying the effects of socio-economic factors on rank-ordering of values in a North Carolina statewide sample, have concluded that, with the exception of race, there is no major reordering of social or personal values resulting from different levels of income or education, or both. Similar results were found by Rokeach (1974).

These studies suggest that there are basic American values which provide an integrative function. Thus, if one or more of these values cannot be maintained, one's degree of social integration will be affected. Older Americans find it increasingly difficult to maintain many American values such as that of work, achievement, and personal freedom. This is caused by factors such as forced retirement, deteriorating physical health, and loss of income. Of key importance are generational value differences and those related to the loss of personal freedom.

Generational Value Differences. Social research indicates that older age cohorts do not have significantly different sets of beliefs than younger age cohorts specifically as a result of age. Rather, age group differences are the result of the socialization of beliefs and practices at different periods of history. One's beliefs, crystallizing in early maturity, reflect basic values which are reasonably stable throughout life. Because of new social conditions and changes in beliefs from one period to the next, successive generations internalize somewhat different sets of values (Bengtson and Kuypers, 1971). Thus,

for example, older age cohorts may define social security and other social services as charity. Younger age cohorts, because they have always given some of their earnings to the social security tax and other services, may be more likely to define these services as a right. However, when considering basic American values such as moral integrity and images of the good life, studies indicate that there are no significant value differences between age cohorts. Studies such as those by Kogan and Wallach (1967), Sidney Goldstein (1960), and Inkeles and Bauer (1959) indicate that older people share many basic beliefs of younger generations, which include consumption preferences, social mobility values and images of the good life (Rosow, 1967). In a more recent study by James Christenson (1977), research was conducted to determine any variation in the relative importance attached to dominant social and personal American values as a result of divergent maturational, historical, and life cycle experiences. From his findings (a North Carolina statewide random sample survey, conducted in 1973) Christenson concluded there are no variations in dominant social values by different age strata. Social values included moral integrity, patriotism, political democracy, helping others, national progress, and racial and sexual equality. Christenson states that "differences in the seven social values seem to be influenced more by income, race, or sex, than by age" (p. 373). In relation to personal values, Christenson found that there was a variation attributable to age. Younger adults attached greater importance to values of work, leisure and achievement; however, this difference was not great. Further, no differences were found in the remaining personal values which included personal freedom, being practical and efficient, material comfort, and

individualism (non-conformity). Christenson states, ". . . no age strata even with adjustment for socioeconomic situations seemed to be radically or even moderately disaffiliated with other age groups toward Williams' dominant values of American society" (1977:373). These values include achievement and success, activity and work, moral orientations, humanitarian mores, efficiency and practicality, progress, material comfort, equality, freedom, external conformity, science and secular rationality, nationalism-patrictism, democracy, individual personality, and racism and related group-superiority themes (Williams, 1960:415-468).

Personal Freedom. Christenson (1977) determined that personal freedom received the highest mean scores among the personal values from all six age groupings (p. 370). Characteristics attributed to an individual's personal freedom by Williams (1951) include individualism, independence, not being subject to restraints that are in some sense external and arbitrary, and ability to be an integral agent, relatively autonomous, and morally responsible (pp. 444-450). Minna Field (1972), to emphasize the importance of personal freedom, states that:

> Independence is universally important and inculcated in the individual from his earliest years. In fact, it is of such importance that it is recognized as one of the three essential requirements in the upbringing of a child in such a way as to insure the preservation of his mental health--the other two being warm love and reasonable discipline. (p. 50)

Likewise, Williams (1951) states that personal freedom produces a particular definition of personal identity: "To be a person is to be independent, responsible, and self-respecting, and thereby to be worthy of concern and respect in one's own right" (p. 435). Thus, it is not surprising that Clark and Anderson, in discussing American cultural values and aging adaptation, state:

> In America, one must simply not admit that, when one grows old, one will need to lean more and more upon others. In America no adult has any right to this. At all cost, the major work must be done, the major values must be acted out. Those who cannot do these things are either 'children' or fools, useless or obsolete. (p. 425)

Similarly, Binstock et al. (1976) has found that older people strive to be not dependent on their children, but rather to master their own environment and destiny. Finally, the President's Council on Aging, emphasizing the importance of personal freedom to older Americans, has stated that "to most older Americans a high degree of independence is almost as valuable as life itself" (Howard, 1969:116-117). Because personal freedom is considered to be an important personal value, one's degree of social integration is threatened when it cannot be maintained.

Personal freedom may not be maintained by older individuals, if, for example, they are forced to receive help from external sources which they define as charity rather than a right. Hendricks and Hendricks (1977) have clarified this condition by stating:

> The failure (of older cohorts) to claim benefits may arise from an ignorance of their availability, but it may also stem from a sense of pride. Many people in their sixties or seventies hold strongly to an ethic of individual responsibility and view governmental assistance programs, and sometimes even Social Security payments, as charity that their self-respect prevents them from accepting. (p. 237)

Elderly cohorts of the future, however, may perceive Social Security benefits as a right not a privilege, primarily because of the large sums of money they will have contributed to Social Security taxes. Studies of the New York Community Service Society (1964) have found that:

> Of the older people served . . . nearly 43 percent . . . were living at or below the Department of Welfare budget level. . . . In spite of their economic straits, less than 40 percent of these persons sought public assistance. . . . Our case workers see these older people clinging to the feeling of self-respect that being self-sufficient gives them. (Howard, 1969:285)

Eugene Barron (1975) has concluded that many older Americans do not seek help because:

> . . . social workers are often tempted to make decisions for them without considering their feelings and needs. When a social worker takes over this way, the aged person feels powerless to change the situation and just gives up, lies in bed, deteriorates, and eventually dies. . . . (p. 230)

Walter M. Beattie (1976) has recognized this problem within the social services and states, "A challenge in the social services is to respond to the older person's needs, while at the same time not increasing his state of dependence" (p. 629). Likewise, Donald Howard (1969) has stated that: "Disguises, it should be noted, are important . . . with respect to beneficiaries who often disdain gratuitous help" (p. 193). Thus, it is apparent that some older individuals have attempted to avoid receiving help from external sources to avoid the loss of personal freedom they associate with it.

In sum, there are dominant shared American values which all generations believe to be important and which provide a socially integrative function. For older Americans these values cannot always be maintained. As a result, to the degree that these values are held, older individuals will experience reduced integration.

Social Integration and Needs of the Elderly

The thesis is based on a descriptive study which examined several need areas of a sample of the elderly in Hampton, Virginia. The social integration framework, as well as other theories, are used in the interpretation of these needs. The need areas examined include: performance of household duties, income maintenance, transportation, participation in clubs and/or organizations, and social visitation. It should be noted that although transportation was examined as a need area, it is

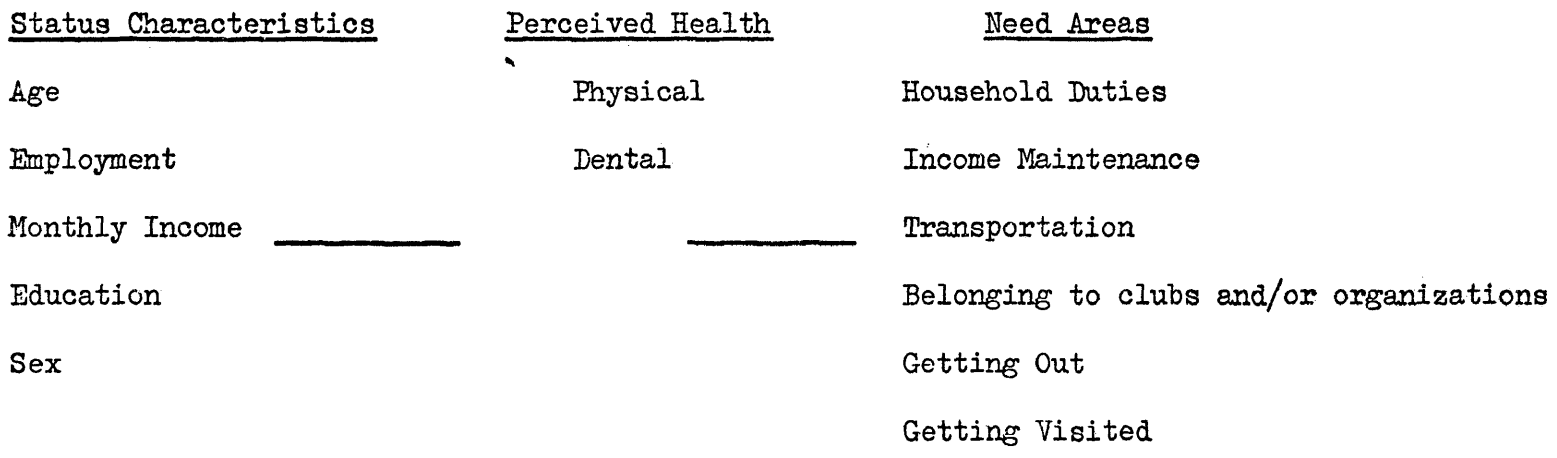
both a means and an end in discussing the needs of the elderly. Transportation is thought of as both means and end in the sense that it is often required for obtaining more basic needs. Also examined in this study are the effects of perceived health and status characteristics on these needs.

The conceptual model depicted in Figure 1 displays possible relationships between status characteristics, perceived health, and the need areas. Perceived health is examined as an intervening variable because it reflects a key physiological dimension of aging. As demonstrated in Figure 1, two dimensions of health are examined and include perceived physical health, and perceived dental health. Though each dimension is examined separately, they are thought of as indicators of health. Status characteristics are examined as either directly affecting need areas or indirectly through the intervening dimensions of health. The status characteristics include sex, age, monthly income, years of education, and employment. The final area examined in the study, but not included in Figure 1, is the desire among the respondents for social service assistance.

When relating Figure 1 to the social integration framework, need areas may be thought of as those behaviors which provide social integration. Belonging to clubs and/or organizations, visiting others, and getting out, provide social integration through social involvement. The ability to perform household duties provides the elderly with social roles and personal independence. Maintaining income provides social integration by helping the elderly avoid charity and maintaining personal freedom. Finally, transportation provides social integration by allowing individuals the mobility often necessary to fulfill social

FIGURE 1

Conceptual Model for Examining Status Characteristics, Health, and Need Areas



roles, involvements, and values. When relating health to the social integration framework, health may be thought of as a determinant of need areas, and consequently, integration. For example, health may affect the need area "getting out" and, consequently, result in reducing social integration. Similarly, the status characteristics listed in Figure 1 are seen as influencing the degree of need and resulting problems of social integration. For example, an elderly person's monthly income may affect his ability to maintain transportation. Loss of transportation may result in reduced social integration. Further, status characteristics may be thought of as indirectly affecting need areas through health. For example, a low monthly income may prevent an individual from receiving adequate health care, resulting in an inability to perform household duties. Finally, with respect to the respondents' desire for social service assistance, receiving assistance may be thought of as affecting one's personal freedom and, consequently, social integration. Thus, the present study examines specific needs of the elderly, as they are influenced by perceived health and status characteristics. The social integration framework as well as other theories will be used to help interpret the findings.

CHAPTER II

METHODOLOGY

The following chapter includes descriptions of: (1) the study area, (2) the sample and data collection procedures, and (3) the methods of data analysis.

Description of the Study Area

Phoebus, Virginia, became a part of the City of Hampton on July 1, 1952. The original City of Hampton consolidated with Elizabeth City County which included the town of Phoebus. The City of Hampton is located at the tip of Virginia's lower peninsula on the Chesapeake Bay and is a part of the Hampton Roads Region, containing almost one million people. Hampton consists of 54.7 square miles and has an inland water area of 17.3 square miles. The residents of Hampton are employed by a variety of industries, businesses, and the military, including the fishing and shipbuilding industries, beach resorts, and Langley Air Force Base, Langley Research Center of the National Aeronautics and Space Administration, and Fort Monroe. Not much land remains available for farming due to extensive urbanization. This urban growth has expanded into the peripheral areas of Hampton, leaving low-income residents in the older, high-density areas such as Phoebus.

Phoebus is located in the southeastern portion of Hampton and covers an area approximately three-fourths of a mile by two miles. Slightly less than half of Phoebus has been singled out by the City of

Hampton, Department of Development, as a low-income area for study. The present study concentrated on determining the perceived needs and preferred social services of the elderly in this portion of Phoebus.

Sample and Data Collection Procedures

The Hampton Department of Development chose the described area in Phoebus for study because of its relatively large concentration of low-income elderly. A door-to-door survey of all residents 55 and over was conducted from February to July 1977 by the Phoebus Social Work Helper. Questions and response categories, concerning various need areas, were read to each interviewee. If an interviewee perceived himself or herself to have one or more needs, then further questions were asked with reference to these needs. In all, 635 residences were contacted. Places of business and houses that were obviously deserted were skipped. Apartments and houses for rent were counted as separate residences. If no one was home at the initial contact, a letter was mailed to the residence. This letter announced the date and approximate time at which the social work helper would return to the residence. In addition, it provided the telephone number of the social work office for those residents who would prefer that the interviewer come on a different day and/or time. This letter is included in Appendix B.

A total of 116 elderly persons were interviewed. A total of 295 residences did not claim to house elderly persons. No response was received from 110 or approximately one-fifth of the residences. Also interviewed, but not included in this study, were all the disabled individuals in the study area.

The questionnaire employed was developed by the Senior Social Worker and is included in Appendix A. The questionnaire was designed

to determine (1) status characteristics, (2) need areas, and (3) preferred social services of the elderly. Status characteristics measured included age, sex, education, and monthly income. Race was not measured. Need areas measured included physical health, dental health, transportation, household duties, income maintenance, and social involvement. Some need areas are measured in terms of respondent's perceptions, while others are measured by implication from their self-reported behavior. Table 1 displays each status characteristic and need area, how they were categorized, and the resulting distribution of responses. When examining age, it can be observed that just over half (52.6 percent) of the respondents are 65 and over, while the remaining 47.4 percent are age 55 to 64. With regard to sex, females make up 60.9 percent of the respondents. Approximately one-fifth (21.9 percent) of the respondents have gone beyond the twelfth grade level. Nearly three-fourths (71.5 percent) of the respondents receive monthly incomes of $328.00 or less. Only 13.8 percent of the respondents are employed, and of these all but one is between age 55 and 64. Thus, after examining the status characteristics, one may conclude that the majority of the respondents in this study are females, 65 and over, with monthly incomes less than $329.00, twelfth grade educations or less, and unemployed.

When comparing the status characteristics of the respondents in this study to the elderly in the general population, it can be observed that these two populations are somewhat similar. With regard to sex, in 1970 females 65 and over made up approximately 58.1 percent of the general population (Woodruff and Birren, 1975:149). Of all the respondents in this study age 65 and over, a total of 65 percent were female.

TABLE 1

FREQUENCIES AND PERCENTAGES OF RESPONDENTS BY POPULATION CHARACTERISTICS AND NEED AREAS

Population Characteristics	Frequency	Percentage (adjusted for missing values)
Age		
55-64	55	47.4
65-74	37	31.9
75-	24	20.7
Sex		
Male	45	39.1
Female	70	60.9
Education		
0-6	33	28.9
7-12	56	49.1
Over 12	25	21.9
Monthly Income		
Under $177	42	36.2
$178-$328	41	35.3
$329-	33	28.4
Employment		
Employed	16	13.8
Not employed	100	86.2
Perceived or Reported Need Areas		
Physical Health		
Fair-Poor	73	64.0
Excellent-Good	41	36.0
Dental Health		
Fair-Poor	59	51.8
Excellent-Good	55	48.2
Household Duties		
Sometimes-Often problem	35	31.5
Comfortable-Able to get by	76	68.5
Income Maintenance		
Some problem-Deep debt	26	22.8
Comfortable-Able to get by	88	77.2

TABLE 1--Continued

Perceived or Reported Need Areas	Frequency	Percentage (adjusted for missing values)
Transportation		
Sometimes-Rarely available	21	18.6
Usually available	92	81.4
Belongs to Club or Organization		
Belongs to one or none	31	26.7
Belongs to two or more	85	73.3
Getting Out		
Gets out less than weekly	38	33.3
Gets out daily-weekly	76	66.7
Friend or relative visits		
Gets visited less than weekly	33	30.6
Gets visited daily-weekly	75	69.4

In 1970 only 11.9 percent of those people 65 and over in the general population had more than a high-school education (Woodruff and Birren, 1975:64). In this study, 25 percent of the respondents 65 and over have more than a high school education. With regard to monthly income, in 1970 approximately 75.0 percent of the general population 65 and over were financially supported by social security alone. In this study, it was found that 71.5 percent of the respondents are in a similar financial condition, receiving $328.00 a month or less. Finally, with respect to employment, in 1970 20.0 percent of the men 65 and over in the general population were still employed (Hendricks and Hendricks, 1977:67). In this study none of the men 65 and over were employed. Thus, these statistics indicate that the majority of individuals 65 and over in the general population of 1970 were reasonably similar to the respondents in this current study in that they were typically females, with low monthly incomes, twelfth grade educations or less, and unemployed. When examining differences which do exist between the two populations, it is apparent that the respondents in the current study have a larger percentage of employed individuals. Possible explanations for these differences include (1) absence of any type of random sampling of respondents in the current study, and (2) social changes which have occurred since 1970, such as the larger percentage of higher educated individuals reaching age 65 (Woodruff and Birren, 1975:65).

To determine the respondent's perceived physical health, the respondent was asked: "Would you say your physical health is: (1) excellent, (2) good, (3) fair, or (4) poor." Perceived dental health was measured in the same way. An examination of Table 1 indicates

that 64.0 percent of the respondents in this study perceived their physical health to be fair or poor, while only 36.0 percent perceived their health to be excellent or good. Table 1 further indicates that 51.8 percent of the respondents in this study perceived their dental health to be fair or poor. The remaining 48.2 percent perceived their dental health to be excellent or good.

The respondent's need for transportation was determined by asking: "Would you say: (1) you usually get transportation to places you want to go, (2) you sometimes get transportation to places you want to go, or (3) you rarely get transportation to places you want to go." The structure of this question does present a problem with interpretation. It is possible that some respondents would not consider walking a mode of transportation, even though they may use it as such. Table 1 indicates 81.4 percent of the respondents in this study usually had transportation available. The remaining 17.2 percent of the respondents have indicated that they sometimes or rarely had transportation.

Perceived ability to accomplish household duties was measured by asking: "Would you say: (1) you are usually able to do household duties by yourself, (2) you are sometimes able to do household duties by yourself, or (3) you are rarely able to do household duties by yourself." Table 1 demonstrates that 68.5 percent of the respondents in this study perceive usually no problem with household duties. The remaining 31.5 percent perceive household problems sometimes to often.

The respondent's employment was determined by asking: "Does your money come from: (a) employment, (b) unemployment compensation, (c) supplemental security income, (d) social security retirement, (e) social security disability, (f) railroad retirement, (g) railroad

disability, (h) other." An examination of Table 1 reveals that 86.2 percent of the respondents are not employed, while the remaining 13.8 percent are employed.

The respondent's social activity was determined from three questions: "How often do you leave your (type of Housing) to do things like visiting friends or shopping? (1) daily, (2) weekly, or (3) less than weekly." "How often does a friend or relative visit you in your (type of housing)? (a) usually daily, (b) at least once a week, (c) at least once a month, (d) less than once a month." "Do you belong to any clubs, churches, or organizations? How many? (a) none, (b) one or two, or (c) three or more." Table 1 demonstrates that 73.3 percent of the respondents reported themselves belonging to two or more clubs and/or organizations, 66.7 percent reported themselves as getting out to visit friends or shop daily or weekly, and 69.4 percent reported themselves getting visited by friends or relatives either daily or weekly.

The respondent's ability for income maintenance was determined by asking: "Would you say you are (1) financially comfortable, (2) able to get by, (3) having financial problems, or (4) deep in debt." Table 1 indicates that 77.2 percent of the respondents perceived being financially comfortable or able to get by, while the remaining 22.8 percent perceived having some financial problems or deep in debt.

Following each question stated above, the respondent was asked if she or he would like to receive social service help with respect to each need area. In reference to physical health, the interviewer asked:

> Which of the following things would you use if they were available?
> a. Someone to do heavy chores for you - things like the laundry, waxing the floor or mowing the lawn.

b. Someone to do things like cooking, cleaning, or maybe helping you to bath or dress.
c. Someone to talk with to help you work out emotional problems, or to make you feel better about yourself and other people.
d. Someone to help you cut down the use of drugs or alcohol.
e. A place to go to several hours each day where you would be with a group of people, have a noon meal and join in social or craft activities.
f. Someone who could get you to the doctor or the hospital if you got very very sick.
g. Help with birth control.
h. Someone to talk with to help you work out your personal or family problems.
i. A place to live where your meals are provided and you get help with some personal things like help dressing or help balancing a check book.
j. Someone to take you to doctor appointments.
k. Someone to help you if you became so ill you might severely hurt yourself or die.
l. A good tasting, hot, cooked meal on a regular basis.
m. Information about how to buy food or prepare meals.
n. Someone to help you get proper medical care.
o. Someone to give you a bath.

After being questioned about dental health, the respondent was asked:

> If help was available, would you like assistance such as help locating a dentist or help obtaining money to pay for dentures or other dental work?
> (a) yes, (b) no, (c) not sure.

In reference to help with household duties, respondents were asked:

> Which of the following things would you use if they were available?
> a. Someone to do heavy chores for you - things like the laundry, waxing the floor or mowing the lawn.
> b. Someone to do things like cooking, cleaning or maybe helping you to bath or dress.
> c. Help in improving skills like balancing a check book or making a monthly budget.
> d. Help in obtaining additional food if you run out of food and money.
> e. Someone to visit you at home to help you do a better job doing things like cooking or budgeting.

After asking questions concerning income maintenance, respondents were asked:

> Which of the following things would you use if they were available?
> a. Help in learning new things - things like learning to read better or learning new craft skills like sewing or woodworking.

b. Help in improving skills like balancing a check book or making a monthly budget.
c. Help in finding a new or better place to live.
d. An attorney to talk to.
e. Help in paying your heating bill if money runs out.

Concerning transportation respondents were asked:

> If help was available would you like to have someone take you to the doctor or the grocery?
> a. Yes
> b. No

With respect to social involvement the interviewer asked two questions:

> Would you take part in any of the following:
> a. A place to go to several hours each day where you would be with a group of people, have a noon meal and join in social and recreational activities.
>
> Can you think of any club or organizations you would join if someone got it started?
> a. None
> b. (list)

Methods of Analysis

Responses to the questionnaires were coded and keypunched on data cards for purposes of computer analysis. The program used to analyze the data was the Statistical Package for the Social Sciences (SPSS), which has become a standard tool of social science research. Cross-tabulations were initially run to determine first-order associations among need areas and between need areas and status characteristics.* It should be noted in this regard that Scalogram analysis was employed to test for unidimensionality among need areas, but no underlying continuum of need was evidenced in the responses. The conceptual model outlined and graphically illustrated at the end of Chapter I was, of course, the principle focus of analysis. The model suggests that the relative effects of status characteristics on perceived physical and

*These are available, on request, from the author.

dental health (key physiological dimensions of aging) be initially determined, and this was followed by an assessment of the effects of these independent and intervening variables on the remaining need areas. Step-wise multiple regression analysis was employed to examine these relationships because of its efficiency in isolating unique effects under statistically controlled conditions. Although the variables were measured at the nominal or ordinal rather than interval level, regression analysis can be justifiably employed for purposes of comparing the relative magnitude of independent variables. Frequency distributions and cross-tabulations provided support for the assumption that variable relationships do not deviate markedly from linearity. A comprehensive correlation matrix for all variables is provided in Table 2.

Standardized betas (Betas), R^2 change, and final R^2 are given for each regression equation, and these are presented in tabular form. The Betas and R^2 change measures indicate the relative power of independent and intervening variables. That is, the larger the Beta coefficient, and/or the greater the independent variance (change) accounted for by an independent variable (R^2 change), the more important the independent variable is in accounting for patterns within a given dependent variable. The final R^2 is the total amount of variance accounted for by all the independent variables. For example, when considering household duties, if R^2 equals .207, then approximately 21 percent of the variance in household duties is explained by the independent variables. The remaining 79 percent of the variance of the dependent variable is unaccounted for and consequently a function of variables not included in this study and/or measurement error. The

TABLE 2

COMPREHENSIVE CORRELATION MATRIX FOR POPULATION CHARACTERISTICS AND NEED AREAS

	V1	V2	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13
V1	1.00	.45	.42	.16	.44	.19	.29	.09	-.13	-.03	.32	.18	.35
V2		1.00	.22	.19	.33	.19	.09	.22	.04	.11	.32	.34	.28
V3			1.00	.06	.51	.04	.11	.18	-.01	.17	.09	.20	.26
V4				1.00	.05	.14	.11	.05	.19	.14	-.02	.09	-.03
V5					1.00	.17	.05	.12	-.16	.02	.29	.22	.26
V6						1.00	-.06	.15	-.00	-.01	.16	.34	.18
V7							1.00	-.17	-.26	-.01	.09	.12	.11
V8								1.00	.12	.21	.04	.12	.17
V9									1.00	.28	-.38	-.25	-.10
V10										1.00	-.15	-.31	-.03
V11											1.00	.35	.21
V12												1.00	.25
V13													1.00

V1 -Physical Health
V2 -Dental Health
V3 -Household Duties
V4 -Income Maintenance
V5 -Getting Out
V6 -Transportation
V7 -Friend or Relative Visits
V8 -Belongs to Club or Organization
V9 -Age
V10-Sex
V11-Employment
V12-Monthly Income
V13-Education

relationship between the desire for social service help and need areas will be analyzed by the examination of frequencies and percentages provided by cross-tabulations and presented in tabular form.

CHAPTER III

RESULTS FROM THE PHOEBUS SOCIAL SERVICE SURVEY OF THE ELDERLY

This chapter summarizes the empirical analysis of the conceptual model depicted in Chapter I. Initially examined are the effects of status characteristics on perceived health. Then the effects of status characteristics and perceived physical and dental health on the remaining need areas are examined. It should be noted that in all cases the variance accounted for in the dependent variables is moderate at best and consequently interpretations should be viewed as highly tentative. This is followed by a discussion of the relationships between need areas and the desire for social service assistance. The chapter concludes with a discussion of the theoretical implications of the findings.

The Effects of Status Characteristics On Perceived Physical and Dental Health

Table 3A demonstrates the extent to which status characteristics account for the two dimensions of perceived health, i.e., physical and dental. When examining physical health, it is clear that education is by far the most influential characteristic, accounting for 12.4 percent of the variance in perceived physical health (Beta = .296). These findings suggest that those individuals with higher education are less likely to perceive physical health problems. The only other status characteristic demonstrating any influence on perceived physical health

TABLE 3

STEP-WISE MULTIPLE REGRESSION ANALYSIS:
PHYSICAL AND DENTAL HEALTH WITH STATUS CHARACTERISTICS

Table 3A:
Physical Health

Status Characteristics	Simple R	R^2 Change	Standardized Beta
Education	.353	.124	.296
Employment	.316	.062	.251
Sex	-.029	.000	.023
Monthly income	.178	.000	.022

R^2 = .186

Table 3B:
Dental Health

Monthly income	.344	.119	.313
Sex	.110	.051	.199
Employment	.317	.048	.273
Age	.044	.028	.188
Education	.282	.027	.171

R^2 = .273

is employment, accounting for 6.2 percent of the variance (Beta = .251). Thus, those respondents who were employed perceived less physical health problems. Status characteristics which do not appear to effect the respondents' perceived physical health in this study include age, sex, and monthly income.

With regard to perceived dental health, Table 3B demonstrates that monthly income is by far the most influential of the given status characteristics, accounting for 11.0 percent of the variance in perceived dental health (Beta = .313). This suggests that as one's monthly income increases, one is more likely to perceive herself or himself in good dental health. Examination of the remaining status characteristics indicate that sex, employment, age, and education have a much less effect on perceived dental health, accounting for 5.1 percent (Beta = .199), 4.8 percent (Beta = .273), 2.8 percent (Beta = .188), and 2.7 percent (Beta = .171) of the variance in perceived dental health, respectively.

In conclusion, the examination of perceived physical and dental health indicates that education, monthly income, and employment are the most influential status characteristics on perceived health. This suggests that to the degree that health affects need areas, education, income, and employment will have an indirect effect on these needs through the intervening health variables.

The Effects of Status Characteristics and Perceived Physical and Dental Health on the Remaining Need Areas

Figure 1 outlined six need areas measured by the questionnaire. These need areas include household duties, income maintenance, transportation, belonging to organized groups, getting out, and getting

visited. The questions used to measure these needs were listed in Chapter II.

Household Duties

Table 4A indicates that physical health is by far the most influential variable on household duties, with a R^2 change of 17.9 percent (Beta = .413). This suggests that those residents who perceive their health as excellent or good are more likely to perceive no problems with household duties. Sex and monthly income are the only status characteristics which directly explain more than 1.0 percent of the variance in household duties, with R^2 changes of 3.4 and 3.7 percent, respectively. This suggests that women in this study were more likely to perceive no problem with household duties than were men. Further, respondents who were recorded as having higher monthly incomes perceived less problem with household duties than those with lower monthly income. Dental health and age account for almost no variance in household duties. Education and employment, though demonstrating no direct effect, may be considered to influence household duties indirectly because of their influence on physical health.

Income Maintenance

Table 4B indicates that no variables demonstrated a noticeable effect on income maintenance. Dental health and age exhibited some influence with R^2 changes of 3.9 (Beta = .090) and 3.5 (Beta = .192) percent, respectively. These statistics indicate that respondents in excellent or fair dental health were more likely to have a comfortable income or able to get by than those with fair or poor dental health. Further, the older the respondent, the more likely she or he was to perceive her or his income as comfortable or able to get by. Other

TABLE 4

STEP-WISE MULTIPLE REGRESSION ANALYSIS:
NEED AREAS WITH STATUS CHARACTERISTICS
AND PERCEIVED PHYSICAL AND DENTAL HEALTH

Table 4A:
Household Duties

Status Characteristics	Simple R	R^2 Change	Standardized Beta
Physical health	.424	.179	.413
Sex	.173	.034	.252
Monthly income	.201	.037	.234
Education	.262	.007	.102
Employment	.099	.005	-.061
Dental health	.224	.004	-.080
Age	-.008	.000	.025

R^2 = .266

Table 4B:
Income Maintenance

Dental health	.196	.039	.090
Age	.195	.035	.192
Physical health	.155	.012	.172
Education	.033	.010	-.129
Monthly income	.056	.009	.154
Sex	.144	.013	.123
Employment	-.016	.001	-.035

R^2 = .118

Table 4C:
Transportation

Monthly income	.349	.122	.362
Physical health	.198	.019	.133
Sex	-.006	.011	.093
Age	-.003	.006	.102
Education	.179	.002	.054
Employment	.159	.001	.042
Dental health	.193	.001	-.035

R^2 = .161

TABLE 4--Continued

Table 4D:
Participation in Clubs and/or Organizations

Status Characteristics	Simple R	R^2 Change	Standardized Beta
Dental health	.223	.049	.113
Sex	.213	.036	.219
Monthly income	.118	.015	.141
Education	.169	.011	.117
Age	.116	.008	.097

R^2 = .119

Table 4E:
Getting Out

Physical health	.437	.191	.312
Employment	.288	.025	.094
Dental health	.329	.014	.103
Education	.258	.006	.071
Age	-.156	.005	-.078
Sex	.021	.003	.084
Monthly income	.224	.005	.088

R^2 = .249

Table 4F:
Friend or Relative Visits

Physical health	.289	.084	.287
Age	-.262	.051	-.265
Employment	.099	.006	-.096
Sex	-.007	.004	.085
Monthly income	.121	.003	.074
Dental health	.095	.000	-.027

R^2 = .149

variables which are listed as having little to no effect include physical health, education, monthly income, sex, and employment. As demonstrated in Table 4B, the total R^2 for income maintenance equals 11.2 percent.

Transportation

An examination of Table 4C reveals that monthly income is by far the most influential variable on access to transportation, with R^2 change of 12.2 percent and standardized beta coefficient of .362. These statistics indicate that those respondents with higher monthly incomes were most likely to have transportation available. Physical health and sex were the only other variables accounting for more than 1.0 percent of the variance on transportation, with R^2 changes of 1.9 percent (Beta = .133) and 1.1 percent (Beta = .093), respectively. These statistics suggest that respondents who perceived their health as excellent or good were more likely to report themselves as "usually having transportation", than those who perceived themselves to be in fair or poor health. Female respondents were more likely to perceive themselves as having available transportation than were male respondents. Other variables demonstrating very little effect upon perceived access to transportation include age, education, employment, and dental health.

Participation in Clubs and/or Organizations

An examination of Table 4D displays no one variable or variables as having noticeable effect upon social participation. Dental health, sex, monthly income, and years of education display some effect, with R^2 changes of 4.9 percent (Beta = .113), 3.6 percent (Beta = .219), 1.5 percent (Beta = .141), and 1.1 percent (Beta = .117), respectively. These statistics indicate that those respondents perceiving themselves

in excellent or good dental health are more likely to report participation in two or more clubs and/or organizations than do respondents perceiving themselves in fair or poor dental health. Women are more likely to report belonging to two or more clubs and/or organizations than men. Respondents with higher monthly incomes are more likely to report themselves in two or more clubs and/or organizations than those with lower monthly incomes. Finally, respondents with greater years of education were more likely to report themselves in two or more clubs and/or organizations than respondents with less education. Age of the respondent showed less than a 1.0 percent effect on participation in organized groups. Further examination of Table 4D demonstrates a total R^2 of 11.0 percent.

Getting Out

An examination of Table 4E displays physical health as being, by far, the most influential variable on getting out, with a R^2 change of 19.1 percent and standardized beta coefficient of .312. This suggests that those respondents who perceived themselves in excellent or good health were more likely to report themselves getting out to do things such as visiting friends and shopping more often than those perceiving themselves in fair or poor physical health. Other variables demonstrating more than 1.0 percent effect on getting out include employment and dental health, with R^2 changes of 2.5 (Beta = .094) and 1.4 (Beta = .103) percent, respectively. Employment may be thought to further affect getting out indirectly through its influence on physical health. These statistics suggest that those who report themselves as employed are likely to perceive themselves as getting out more often than those unemployed. Further, respondents perceiving themselves in

excellent or good dental health are likely to report themselves as getting out more often than respondents perceiving themselves in fair or poor dental health. Other variables which demonstrated only a very small effect on getting out include age, sex, and monthly income. Education, though demonstrating no direct effect, may be considered to influence getting out indirectly, through its influence on physical health.

Friend or Relative Visits

Examination of Table 4F displays physical health and age as being the most influential variables on getting visited, with R^2 changes of 8.4 (Beta = .287) and 5.1 (Beta = -.265) percent, respectively. These statistics suggest that respondents who perceived themselves to be in excellent or good health were likely to report themselves getting visited by friends or relatives more often than respondents perceiving themselves in fair or poor physical health. Further, the younger the respondent indicated herself or himself to be, the more often she or he reported getting visited by friends or relatives. Other variables which demonstrated only a very small effect on getting visited include sex, monthly income, and dental health. Education and employment, though demonstrating no direct effect, may be considered to indirectly influence visits to elderly persons by friends and relatives, through their influence on physical health.

In conclusion, a review of the data reveals that of all the independent variables examined, physical and dental health displayed the greatest association with each of the need areas, except for transportation. Monthly income was found to be the next variable most associated with the need areas. It is important to note that in most cases,

variances accounted for in the independent variables were modest. Consequently, even though relationships may appear to follow anticipated directions, any interpretations should be considered tentative at best.

Relationship Between Need Areas and Desire for Social Service Help

Respondents were asked if they would prefer social service help with respect to each of the need areas. Table 5 demonstrates that the large majority of respondents did not desire social service help with any of the need areas except for perceived health. Only 8.9 percent of the respondents desired help with transportation, 7.9 percent with income maintenance, 3.0 percent with household duties, and, on the average, 2.6 percent with social activities, such as getting visited, belonging to organized groups and getting out. When considering perceived health, 47.2 percent of the respondents reported a desire for social service help with physical health and 47.8 percent with dental health. The obvious but important conclusion is that there is little apparent relationship between empirically identified needs and the desire to receive social service assistance, except for physical and dental health.

With specific reference to perceived physical and dental health, Table 1 demonstrated that 64.0 and 51.8 percent of the respondents perceived their physical and dental health as fair or poor. Table 5 indicates that the percentages of respondents desiring help for physical and dental health are 47.2 and 47.8 percent, respectively. Further examination of Table 5 reveals that the desire for help in these areas does not appear to be related to the respondents' perceived physical or dental health condition, as is indicated by the large

TABLE 5

RELATIONSHIPS BETWEEN NEED AREAS AND DESIRE FOR SOCIAL SERVICE ASSISTANCE

Need Areas	Desire for Social Service Assistance			
	Yes (percent)	No (percent)	Not Sure (percent)	Total Frequency
Physical health	47.2	58.8	-	114
Fair-Poor	31.7	68.3	-	41
Excellent-Good	46.6	53.4	-	73
Dental health	47.8	28.3	23.9	113
Fair-Poor	30.9	38.2	30.9	55
Excellent-Good	63.8	19.0	17.2	58
Household Duties	3.0	97.0	-	99
Sometimes-Often problem	2.9	97.1	-	69
Usually no problem	3.3	96.7	-	30
Income Maintenance	7.9	92.1	-	114
Some problem-Deep debt	15.4	84.6	-	26
Comfortable-Able to get by	5.7	94.3	-	88
Transportation	8.9	91.1	-	112
Sometimes-Rarely available	20.0	80.0	-	20
Usually available	6.5	93.5	-	92
Belongs to Club and/or Organization	2.8	97.2	-	106
Belongs to one	0.0	100.0	-	29
Belongs to two or more	3.9	96.1	-	77
Getting Out	2.9	97.1	-	105
Getting out less than weekly	3.0	97.0	-	33
Getting out daily-weekly	2.8	97.2	-	72
Friend or Relative Visits	2.0	98.0	-	102
Gets visited less than weekly	3.2	96.8	-	31
Gets visited daily-weekly	1.4	98.6	-	71

percentage of respondents perceiving their health as excellent or good and also indicating a desire for social service help with respect to health.

Application of the Findings To Theories in Gerontology

The remainder of this chapter will examine those theories in gerontology which appear to provide some useful interpretations for the previously stated findings. These interpretations will deal first with those variables affecting the need areas, followed by an examination of the respondents' desires for social service help.

Applying Gerontological Theory to the Respondents' Reported Needs

An examination of Table 4 revealed that perceived health was found to be the most important variable in accounting for patterns within all but one of the need areas. Some gerontological theories anticipate health problems as a biological consequence of aging. The developmental theory, with its specific emphasis on biological changes, is perhaps the most explicit in examining physical deterioration in old age. This examination of biological changes includes areas such as cellular development and decay, the gradual reduction of the senses, vulnerability to disease, the effects of stress, and the advantages of exercise. Other gerontological theories, however, examine the personal and social problems caused by physical deterioration, rather than the causes of these biological changes. The most comprehensive of these theories appears to be the social integration framework, which views physical deterioration as a primary factor producing reduced social integration. This conceptual framework suggests that physical problems cause a reduction in one's social roles, social involvements, and shared

social values. For example, physical problems may result in immobility, causing an individual to drop out of her or his work and/or group membership roles, cease getting out, and be forced into accepting what may be defined by the elderly person as charity. The findings of this study support the social integration framework by showing that respondents who perceived fair or poor health were more likely to report problems with maintaining social roles and social involvement. These include household duties and getting out, and to a lesser extent, participation in clubs and/or organizations, income maintenance, and transportation.

An examination of Tables 3 and 4 demonstrated that monthly income was a second variable which accounted for some variance in several of the need areas. The activity theory has initiated several studies which have perhaps most directly pointed to the importance of monthly income. These studies, while attempting to show a relationship between social activities and life satisfaction, have, in several cases (Spreitzer and Snyder, 1974; Cutler, 1973; Edwards and Klemmack, 1973), found that one's income as well as physical health are possibly the most important variables. When applying the social integration framework specifically to monthly income, it suggests that the elderly person's income will affect her or his social roles and involvements. For example, at retirement, most elderly persons' net incomes are substantially reduced. This may result in monetary problems affecting the elderly person's financial ability to maintain adequate health and transportation, and/or financially support clubs and/or organizations. When applying the social integration framework to the findings of this study concerning monthly income, it is found that it does provide a

useful interpretation. Reported monthly income was found to be an important variable in accounting for variance in several of the need areas, which included transportation and dental health, and to a lesser degree, perceived maintenance of household duties and participation in clubs and/or organizations.

Examination of Tables 3 and 4 demonstrated that sex was a third variable which accounted for some variance in several need areas. One gerontological theory providing an interpretation for the influence of sex is role theory, which is also encompassed within the social integration framework. Role theory suggests the basic postulate that men and women will enact different roles and that these roles provide divergent experiences. For example, men tend to emphasize instrumental (work) roles while women emphasize socioemotional roles. By implication, the enactment of non-traditional roles will create problems for both men and women because of their lack of experience in dealing with the demands associated with these roles. In this study men perceived greater problems in the performance of household duties and reported lower club and/or organization participation. Role theory suggests that men will have greater difficulty with these areas because the roles subsumed by them have been traditionally left to women.

Age is a fourth variable portrayed in Table 4 which accounted for some variance within several need areas. Once again the social integration framework is useful because it suggests that an individual's age is related to her or his ability to maintain social roles and involvements. The social integration framework emphasizes the fact that Americans are forced to retire at a specific age unless self-employed. At the specified age of retirement, individuals experience a decline

in living resources and consequently perceive problems with maintaining their incomes, unless they have other sources of income such as stocks. Once adjusting to this reduction of income, elderly individuals are less likely to perceive income maintenance problems. A second finding which was expected as a product of differential mortality suggests that the older the individual, the greater the possibility that members of her or his nuclear and extended families, as well as long-time friends, will have died. Consequently, as an individual grows older, she or he will receive fewer visits from family and long-time friends because there will be fewer still alive to pay a visit. Both of these patterns were documented in the present study.

Education also demonstrated some effects on patterns of need. The social integration framework suggests that elderly individuals who are informed about new advances in science, technology, and health care will be better able to adjust to occupational changes and keep in better physical health. The present study did provide clear support for the positive relationship between education and perceived health. Since it is reasonable to assume that level of education is related to being better informed about ways of maintaining health, the study provides at least indirect support for the social integration framework.

The final independent variable to be considered is employment. The activity theory as well as the social integration framework suggest that elderly individuals would prefer to work, rather than retire, if (1) there are no comparable roles to provide the social activities or integration provided by the work role, and/or (2) there is a reduction in income to the extent that the individual's social activities or integration is lessened, and/or (3) the individual does not perceive

significant problems with her or his health. The present study showed that those individuals who reported themselves to be employed were more likely to also report better physical and dental health and more likely to engage in visitation. These findings suggest that employment is both an effect and a cause of better physical health. It is an effect in the sense that better health allows for continuing work and a cause in the sense of a presumed relationship between keeping active and maintaining health. Certainly age is an important underlying variable in this process because it is used as an arbitrary factor in cutting off employment opportunities. We note again, however, that age did not exhibit any direct effect on perceived health in this study. Finally, we suspect that social visitation is a logical extension of the social integrative benefits of employment. We note, however, that these benefits are specific to social visitation because there was no relationship between employment and organizational involvement.

Applying Gerontological Theory to the Respondents' Desire for Social Service Help

The social integration framework and continuity theory are two gerontological perspectives which appear to provide some interpretation to the findings previously stated concerning the desire for social service help. Each is discussed below as it relates to these findings.

The social integration framework suggests that there are basic values which create integrative bonds and social solidarity. When one or more of these values is not practiced, then one's social integration is lessened. Personal freedom has been found to be the most important personal value in American society today. Consequently, when personal freedom is not maintained, such as when an individual receives what is

perceived to be charity, social integration is lessened. Thus, with regards to receiving social service help, this framework suggests that when social service help is perceived as charity, it will be avoided.

The findings in Table 5 demonstrate that almost 50 percent of the respondents desire help with physical and dental health, while less than 10 percent desire help with income maintenance and/or transportation; and, 3 percent or less of the respondents desire help with household duties and/or social involvement. These rates are, of course, far lower than those of perceived or reported needs in those areas. A further examination of Table 5 reveals that those respondents who do desire help with physical and/or dental health, do so regardless of their own perceived physical and/or dental health.

The general implication derived from Table 5 is that most elderly respondents in this study may have perceived the receiving of social service help as a charity rather than a right; and, consequently, they wished to avoid receiving such help. In the case of those respondents who did report a desire for social service assistance with one or more needs, a social integration framework suggests that these respondents either defined this assistance as a right, or defined their situation as one in which their current or eventual need for social service help was more important than the lessened social integration associated with receiving the social service help.

What is the origin of this negative definition of social services assistance? Continuity theory contends that individuals obtain their values at a relatively young age and then carry these values into their later years of life. By implication, the respondents in this study obtained their values toward receiving social service help in the early

1900's when they were relatively young. At that time the Social Security tax had not yet been instituted, there was little governmental aid to the elderly, and what was provided both publicly and privately was defined as goodwill or charity. Thus, continuity theory suggests that the respondents in this study obtained their definition of receiving social service help as charity when they were relatively young and have carried it into their later years of life.

In conclusion, one-fifth to one-third of the elderly perceive having a need with the areas examined. Part of this need is accounted for by health and to a slight degree status characteristics. Less than 10 percent of the respondents desire assistance with these needs, although over half desire assistance with health. Thus, there is little apparent relationship between empirically identified needs and the desire to receive social service assistance, except for physical and dental health.

CHAPTER IV

CONCLUSIONS

The final chapter briefly summarizes the research findings and theoretical relevance of these findings, then suggests a few general policy implications derived from the present study. The chapter concludes by suggesting directions for future research.

Substantive Findings

Examination of the various need areas indicated that approximately one-fifth to one-third of the respondents have problems with them. Specifically, in order of magnitude, 33.0 percent of the respondents indicated getting out less than weekly, 31.5 percent indicated having a problem performing household duties, 30.6 percent indicated they get visited less than weekly, 26.7 percent belong to one or no club and/or organization, 22.8 percent have some problem with income maintenance or are deep in debt, and finally, 18.6 percent obtain transportation only sometimes or rarely.

Examination of the influence of perceived health indicated that it accounts for moderate variance in various need areas. Specifically, health accounts for 20.5 percent of the variance in getting out, 18.3 percent in performing household duties, 8.7 percent in friends or relatives visiting, and 5.1 percent in income maintenance. When examining each dimension of health, it was found that 64.0 percent of the respondents perceived their physical health as fair or poor, while 51.8

percent of the respondents perceived their dental health as fair or poor. Further examination of these dimensions revealed that several status characteristics account for moderate variance in perceived health. When considering physical health, these included education (12.4 percent) and employment (6.2 percent). When considering dental health, only monthly income (11.9 percent) accounted for much variance.

Examination of the effects of status characteristics on need areas indicated that they account for far less variance. For example, only 4.5 percent of the variance in getting out is accounted for by all the status characteristics combined. This was found to be typical for all need areas. The only status characteristic which stood out from the remaining characteristics was monthly income, accounting for 12.2 percent of the variance in transportation. However, education, employment, and monthly income were found to have an indirect effect on the need areas because of their direct effects on health.

Examination of the respondents' desire for social service assistance indicated that less than 10 percent of the respondents reported a desire for assistance with need areas. However, slightly more than half of the respondents reported a desire for assistance with health.

Theoretical Implications

The substantive findings provide some illumination of the social integration framework. First, the documented needs among the elderly suggest that they do have a problem with social integration. For example, with respect to social involvement, a third of the respondents reported getting out to do things like visiting others and shopping less than once a week. With respect to social roles, approximately a

third of the respondents reported sometimes or often having a problem with performing household duties. With respect to social values, it appears the elderly are attempting to practice these, as is indicated by their desire to avoid receiving social service assistance. Only the desire for health assistance is an exception. Second, the effect of the respondents' health on these needs suggests that health plays a major role in determining an elderly person's degree of social integration. Third, the direct effects of status characteristics on the needs suggest they play only a modest role in determining an elderly person's degree of social integration. The major exception is the relationship between monthly income and transportation, with monthly income accounting for 12.2 percent of the variance. However, education, employment, and income do indirectly influence the need areas and thus relate to the degree of social integration. These effects are mediated by the key intervening variable of health. Finally, the fact that respondents generally decline the offer of social service assistance with their needs, suggests that they prefer the social value of personal freedom, and the social integration implied by that value. With respect to health, the majority of the respondents do desire social service assistance. Improved health can reduce other need areas and consequently allow for increased social integration. For example, improved health could result in increasing the respondents' social involvement such as getting out more often, and increasing social roles such as performing household duties.

In conclusion, the findings suggest that social integration may indeed be a problem for a significant minority of the elderly. This problem is notably heightened by poor health, and to a modest degree,

by status characteristics of individuals.

Policy Implications

From the findings we can conclude that one-fifth to one-third of the respondents need help maintaining income, obtaining transportation, performing household duties, participating in organized groups, getting out, receiving visits from friends and relatives, and/or improving their health. There are several policies which can help the elderly with these problems.

The findings suggest that improved health among the elderly will lessen the needs examined and consequently provide the ability for increased social integration. There are several policies which can help the elderly improve their health. The elderly can be provided more extensive medical coverage. This can be accomplished through either a more comprehensive Medicare program or a national health care program which covers all costs of health care. Further, medical schools can provide medical training for doctors specifically aimed at health problems commonly found among older persons. The findings indicate that education, employment, and monthly income account for moderate variance in perceived health. Consequently, it appears an extensive educational campaign designed to inform the elderly of findings on good health care would result in improved health among the elderly. Further, information might point out to the elderly services available to them, as well as provide explanations of Medicare, Medicaid, and Social Security benefits. Information might be provided by special publications, visiting lecturers, and special courses.

With regard to employment and monthly income, there are several means of helping the elderly. For example, Social Security benefits

could be increased and mandatory retirement could be abolished. This would provide retired individuals with a more substantial income and allow elderly persons to maintain their working incomes for a longer period of time if they wish to do so. Further, it would make increased Social Security benefits more economically feasible. Currently there are several government-funded programs designed to accomplish this end. The Department of Labor has supplied funds to the National Council of Senior Citizens for their Senior AIDES program (Alert, Industrious, Dedicated, Energetic Service). Their projects have dealt primarily with health and social welfare (Jonas and Jonas, 1973:209). Project WORK (Wanted: Older Residents with Know-how) in Long Beach, California, succeeded in placing more than fifty elderly applicants in productive jobs, despite a high rate of unemployment in that area (Jonas and Jonas, 1973:210). Late Start, sponsored by the National Retired Teachers Association and the American Association of Retired Persons, is designed to develop latent skills and interest opportunities among the elderly for helping others. They work as paid employees or volunteers. Finally, the Green Thumb program, set up by the National Farmers Union and funded by the Department of Labor, hire elderly persons part-time. In this program in 1970, more than 2,400 low-income elderly improved or built more than 350 roadside parks; planted more than one million trees, flowers, and shrubs; cleaned out lakes; built picnic areas and campgrounds; and helped restore and develop historic sites (Jonas and Jonas, 1973:217). Unfortunately, many work projects for the elderly are dependent on grants. A more permanent program for employment could be provided.

In addition to focusing on health, education, and income, policy

can be directed to the particular needs in question. However, the results of the study indicate that less than 10 percent of the respondents desire help with any particular need. The reason for this appears to be related to social values. With an extensive educational campaign, the elderly may be more willing to receive assistance when they need it. Further, as new cohorts reach their senior years, they will be more likely to define social service assistance as a right and consequently desire assistance when it is needed.

For those elderly who currently desire assistance, there are several programs which can be implemented to assist them. Transportation can be provided, possibly by an organized taxi system, to help elderly persons get out of their houses to do those things they wish to do. For those elderly interested in social involvement, a senior citizens' center can be provided for leisure activities, with transportation provided to and from the center. For those elderly interested in voluntary organizations, there are currently many available. Several years ago the Administration on Aging recommended that legislation be enacted to "provide new opportunities for community service for senior citizens who would serve their community without compensation except for reimbursement for transportation, meals, and out-of-pocket expenses" (Jonas and Jonas, 1973:238). Since that time many government-sponsored voluntary organizations have been developed. The Retired Senior Volunteer Program (RSVP) tries to match work and service with the elderly volunteers seeking them. This work can, for example, include counseling and tutoring schoolchildren or the retarded, assisting schools as lunchroom supervisors, playground monitors, or teaching aides. Another example is a program called Foster Grandparents, designed to make the lives

of children confined to institutions happier. Since its beginnings, it has been expanded to include mental health clinics, hospitals, correctional institutions, day centers, and classes for exceptional children. The Service Corps of Retired Executives (SCORE) is a voluntary organization whereby retired executives help small businessmen through consulting. A fourth voluntary organization which might be considered by the elderly includes advisory panels made up of retired scientists and researchers, which may include physicians, technicians, scientific consultants, teachers, and writers. Company laboratories and college facilities can be made available for these retired persons to do their own research projects which they would like to carry out. Further, elderly persons may choose to develop Senior Citizen Clubs and similar groups, often organized at Senior Citizen or Nutrition Centers. Finally, for those elderly who desire assistance with household duties, assistance could be provided by sending a helper to the elderly person's home.

In conclusion, there are many policy implications stemming from this study which can be implemented to assist the elderly with their needs. These cover health, education, income, transportation, social involvement, and household duties.

Direction for Further Research

It is likely that there are other unidentified needs among the elderly in Phoebus. Additional studies in other areas outside of Phoebus should be conducted in order to determine the perceived needs and desires of a larger portion of the elderly. Further, evaluative research on current programs being provided should be conducted to determine the effectiveness of these programs in addressing needs and

APPENDICES

APPENDIX A

PHOEBUS NEEDS ASSESSMENT SURVEY

HOUSEHOLD INFORMATION

HOUSEHOLD IDENTIFICATION NUMBER: _____

NUMBER OF HOUSEHOLD MEMBERS: _____

NUMBER OF PERSONS OVER 55: _____

NUMBER OF HANDICAPPED PERSONS: _____

TYPE OF HOUSING (Circle):

a. Single Dwelling Home

b. Duplex

c. Apartment

d. Mobile Home

e. Room with access to cooking facilities

f. Room with board

g. Other: _____

PHOEBUS NEEDS ASSESSMENT SURVEY

INTERVIEWEE INFORMATION

HOUSEHOLD IDENTIFICATION NUMBER: _____

INTERVIEWEE IDENTIFICATION NUMBER: _____

(Circle unless otherwise indicated)

a. Handicapped b. 55 years and older

AGE: _____

SEX: a. Female

b. Male

DOES YOUR MONEY COME FROM:

a. Employment,

b. Unemployment Compensation,

c. Supplemental Security Income, SSI,

d. Social Security Retirement,

e. Social Security Disability,

f. Railroad Retirement,

g. Railroad Disability, or

h. Other: _____

WOULD YOU SAY YOUR MONTHLY INCOME IS:

a. Under $177,

b. Between $178 and $328,

c. Between $329 and $400,

d. Between $401 and $500, or

e. Over $500.

DO YOU HAVE MEDICARE?

a. Yes

b. No

c. Not Sure

DO YOU HAVE MEDICAID?

a. Yes

b. No

c. Not sure

Phoebus Overview Sheet

A. Would you say your physical health is:

1. Excellent
2. Good
3. Fair (Go to health Q1)
4. Poor (Go to health Q1)

B. Would you say your teeth/dentures are in:

1. Excellent condition
2. Good condition
3. Fair condition (Go to dental health Q1)
4. Poor condition (Go to dental health Q1)

C. Would you say:

1. You are usually able to do household duties by yourself.
2. You are sometimes able to do household duties by yourself. (Go to H. Man. Q.1)
3. You are rarely able to do household duties by yourself. (Go to H. Man. Q.1)

D. Would you say you are:

1. Financially comfortable
2. Able to get by financially
3. Having financial problems (Go to Inc. Main. Q1)
4. Deeply in debt (Go to Inc. Main. Q1)

E. How often do you leave your (type of housing) to do things like visiting friends or shopping?

1. Daily
2. Weekly (Go to Com. -Soc. Inv. Q1)
3. Less than weekly (Go to Com. -Soc. Inc. Q1)

F. Would you say:

1. You usually get transportation to places you want to go.
2. You sometimes get transportation to places you want to go. (Go to Trans. Q1)
3. You rarely get transportation to places you want to go (Go to Trans. Q1)

G. Would you say:

1. You are generally satisfied with the jobs you have or had.
2. You are generally dissatisfied with the jobs you have or had. (Go to Empl. Q1)

H. Would you say:

1. You are generally satisfied with the education you had.
2. You are generally dissatisfied with the education you had (Go to Ed. Q1)

HEALTH

1. DO YOU HAVE A DOCTOR YOU GO TO?

    a. Yes (Go to Q2)

    b. No (Go to Q6)

    c. Not sure (Go to Q7)

2. HOW OFTEN DO YOU SEE A DOCTOR?

    a. At least once a month

    b. Every 2 or 3 months

    c. At least twice a year

    d. At least once a year

    e. Less than once a year

3. WOULD YOU LIKE TO SEE A DOCTOR MORE OFTEN?

    a. Yes

    b. No

    c. Not sure

4. DO YOU HAVE MORE THAN ONE DOCTOR?

    a. Yes

    b. No

    c. Not sure

5. WOULD YOU SAY YOU ARE GETTING:

    a. The best possible health care,

    b. Satisfactory health care, or

    c. That you are not satisfied with your health care.

    (Go to Q7)

HEALTH - 2 -

6. WHY DON'T YOU HAVE A DOCTOR?

   a. Too expensive

   b. Don't know which one to go to

   c. Don't need one

   d. Other: _____

7. DO YOU HAVE ANY HEALTH PROBLEMS THAT SHOULD BE TREATED BY A DOCTOR?

   a. Yes

   b. No

   c. Not sure

   (Go to Q)

8. IN THE NEXT YEAR DO YOU EXPECT YOUR HEALTH TO:

   a. Improve

   b. Remain about the same, or

   c. Get worse

9. WHICH OF THE FOLLOWING THINGS WOULD YOU USE IF THEY WERE AVAILABLE?

   a. Someone to do heavy chores for you - things like the laundry, waxing the floor or mowing the lawn. (Chore Services)

   b. Someone to do things like cooking, cleaning or maybe helping you to bath or dress. (Companion)

   c. Someone to talk with to help you work out emotional problems, or to make you feel better about yourself and other people. (Counseling and Treatment Services)

   d. Someone to help you cut down the use of drugs or alcohol. (Counseling and Treatment Services)

e. A place to go to several hours each day where you would be with a group of people, have a noon meal and join in social or craft activities. (Day Care)

f. Someone who could get you to the doctor or the hospital if you got very, very sick. (Emergency Needs)

g. Help with birth control. (Family Planning Services)

h. Someone to talk with to help you work out your personal or family problems. (Family and Personal Adjustment Counseling)

i. A place to live where your meals are provided and you get help with some personal things like help dressing or help balancing a check book. (Foster Care Services for Adults)

j. Someone to take you to doctor appointments. (Transportation)

k. Someone to help you if you became so ill you might severely hurt yourself or die. (Protective Services)

l. A good tasting, hot, cooked meal on a regular basis.

m. Information about how to buy food or prepare meals. (Nutrition)

n. Someone to help you get proper medical care.

o. Someone to give you a bath. (Homemaker)

DENTAL HEALTH

1. DO YOU HAVE A DENTIST YOU GO TO?

    a. Yes (Go to 2)

    b. No (Go to 3)

    c. Not sure (Go to 4)

2. HOW OFTEN DO YOU SEE A DENTIST?

    a. More than twice a year

    b. At least twice a year

    c. At least once a year

    d. Less than once yearly

    (Go to 4)

3. WHY DON'T YOU HAVE A DENTIST?

    a. Too expensive

    b. Don't know which one to go to

    c. Don't need one

    d. Other: _____

4. WHAT CONDITION WOULD YOU SAY YOUR TEETH/DENTURES AND GUMS ARE IN?

    a. Excellent

    b. Good

    c. Fair

    d. Poor

DENTAL HEALTH - 2 -

5. DO YOU HAVE ANY TEETH OR GUM PROBLEMS THAT SHOULD BE SEEN BY A DENTIST?

   a. Yes

   b. No

   c. Not sure

6. IF HELP WAS AVAILABLE WOULD YOU LIKE ASSISTANCE SUCH AS HELP LOCATING A DENTIST OR HELP OBTAINING MONEY TO PAY FOR DENTURES OR OTHER DENTAL WORK?

   a. Yes

   b. No

   c. Not sure

HOME MANAGEMENT

1. OF THE FOLLOWING THINGS LISTED, ARE THERE ANY YOU NEED HELP DOING? (Check)
   DOES SOMEONE NOW HELP YOU WITH ANY OF THE FOLLOWING THINGS LISTED? (Check)

TASK	NEEDS HELP	GETS HELP
PURCHASE FOOD		
MEAL PREPARATION		
BUSINESS DEALINGS (PAY BILLS)		
PERSONAL CARE (BATHING, DRESSING)		
LIGHT CHORES (DISHES, DUSTING)		
HEAVY CHORES (VACUUMING, LAUNDRY)		
OTHERS: _____		

2. WHICH OF THE FOLLOWING THINGS WOULD YOU USE IF THEY WERE AVAILABLE?
   a. Someone to do heavy chores for you - things like the laundry, waxing the floor or mowing the lawn. (Chore Services)
   b. Someone to do things like cooking, cleaning or maybe helping you to bath or dress. (Companion Services)
   c. Help in improving skills like balancing a check book or making a monthly budget. (Education and Training Services)
   d. Help in obtaining additional food if you run out of food and money. (Emergency Needs)
   e. Someone to visit you at home to help you do a better job doing things like cooking or budgeting. (Homemaker)

INCOME MAINTENANCE

1. WOULD YOU SAY THAT YOU ARE:

    a. Financially comfortable.

    b. Able to get by financially,

    c. Having financial problems, or

    d. Deeply in debt.

2. DO YOU HAVE ANY SAVINGS?

    a. $1500.00 or more

    b. Less than $1500.00

    c. None

3. HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS IN THE LAST YEAR? (Circle as many as apply)

    a. Eviction for not paying rent.

    b. Gas or lights turned off for not paying.

    c. No heat because money ran out.

    d. No food or money to buy more.

    e. Furniture, etc. repossessed

    f. Other: _____

    g. None (Go to Q 5)

4. WOULD YOU SAY YOU HAVE THESE TYPES OF PROBLEMS:

    a. Just about every month,

    b. Occasionally, or

    c. Very rarely.

INCOME MAINTENANCE - 2 -

5. DO YOU EXPECT TO HAVE FINANCIAL PROBLEMS IN THE NEXT YEAR?

   a. Yes

   b. No

   c. Not sure

6. WHICH OF THE FOLLOWING THINGS WOULD YOU USE IF THEY WERE AVAILABLE?

   a. Help in learning new things - things like learning to read better or learning new craft skills like sewing or wood-working. (Education and Training Services)

   b. Help in improving skills like balancing a check book or making a monthly budget. (Education and Training Services)

   c. Help in finding a new or better place to live.

   d. An attorney to talk to. (Legal Services)

   e. Help in paying your heating bill if money runs out. (Emergency Needs)

COMMUNITY AND SOCIAL INVOLVEMENT

1. HOW OFTEN DOES A FRIEND OR RELATIVE VISIT YOU IN YOUR (TYPE OF HOUSING)?

    a. Usually daily

    b. At least once a week

    c. At least once a month

    d. Less than once a month

2. HOW OFTEN DO YOU VISIT FRIENDS OR RELATIVES IN THEIR HOMES?

    a. Usually daily

    b. At least once a week

    c. At least once a month

    d. Less than once a month

3. DO YOU BELONG TO ANY CLUBS, CHURCHES OR ORGANIZATIONS? HOW MANY?

    a. None

    b. One or two

    c. Three or more

4. DO YOU RECEIVE THE PAA NEWSLETTER?

    a. Yes

    b. No

    c. Not sure

5. DO YOU HAVE A TELEPHONE?

    a. Yes

    b. No

COMMUNITY AND SOCIAL INVOLVEMENT - 2 -

6. CAN YOU THINK OF ANY CLUB OR ORGANIZATIONS YOU WOULD JOIN IF SOMEONE GOT IT STARTED?

   a. None

   b. (List)_____

   _____

   _____

7. WOULD YOU TAKE PART IN ANY OF THE FOLLOWING?

   a. A place to go to several hours each day where you would be with a group of people, have a noon meal and join in social and recreational activities. (Day Care)

   b. A group meeting once a week discussing topics of interest or doing craft projects.

TRANSPORTATION

1. HOW DO YOU GET TO THE GROCERY STORE? THE DOCTOR? (Check)

MODE OF TRANSPORTATION	GROCERY STORE	DOCTOR
Personal car		
Relative's car		
Non-relative's car		
Taxi		
Bus		
Walking		
Other: _____		
Other: _____		

2. WOULD YOU LEAVE HOME MORE OFTEN IF THERE WAS AN EASIER WAY TO GET PLACES?

   a. Yes

   b. No

   c. Not sure

3. IF HELP WAS AVAILABLE WOULD YOU LIKE TO HAVE SOMEONE TAKE YOU TO THE DOCTOR OR THE GROCERY STORE?

   a. Yes

   b. No

EMPLOYMENT

1. DO ANY OF THE FOLLOWING DESCRIBE YOU?

    a. Employed full time.

    b. Employed part-time

    c. Wants a full time job.

    d. Wants a part-time job.

    e. Wants to earn extra money.

    f. Looking for higher paying job.

    g. Dissatisfied with work.

    h. Unemployed and not looking for a job.

    i. Other: _____

2. WHICH OF THE FOLLOWING THINGS WOULD YOU USE IF THEY WERE AVAILABLE?

    a. Information about how to find out about job openings.

    b. Information about where you can improve job related skills.

    c. Information about programs helping handicapped people return to work.

EDUCATION

1. HOW MANY YEARS OF EDUCATION DO YOU HAVE?

    a. 0 - 3

    b. 4 - 6

    c. 7 - 9

    d. 10 - 12

    e. 1 - 2 College

    f. 3 - 4 College

    g. Graduate

2. IF YOU HAD GONE TO SCHOOL LONGER, WOULD IT HAVE MADE YOU MORE SUCCESSFUL?

    a. Yes

    b. No

    c. Not sure

3. WOULD YOU NOW LIKE TO GET ADDITIONAL EDUCATION?

    a. Yes

    b. No

    c. Not sure

4. IF HELP WAS AVAILABLE WOULD YOU LIKE ASSISTANCE SUCH AS HELP TO OBTAIN A GED OR BASIC EDUCATION, HELP IN ENTERING A COLLEGE ENRICHMENT COURSE, OR HELP IN JOINING SKILL AND CRAFT GROUPS?

    a. Yes

    b. No

    c. Not sure

APPENDIX B

LETTER LEFT TO RESIDENTS NOT AT HOME

Dear Phoebus Resident:

I am conducting a door-to-door survey for the Hampton Department of Social Services to determine the need for Social Services in this area.

I am interviewing disabled persons and persons 55 or more years old.

Since you were not home when I stopped by today, I will return on _____ between _____ and _____.

If this is an inconvenient time for you, it would be most helpful if you could telephone me at 723-6081, extension 308 to make an appointment.

Your cooperation with this survey will assist us in attempting to provide the best possible social services to Phoebus.

Thank you.

Sibyl Moyer
Survey Interviewer

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